

### § 220.3

### 32 CFR Ch. I (7–1–10 Edition)

beneficiary were to incur the costs on the beneficiary's own behalf.

(b) *Application of cost shares.* If the third party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, then the amount the United States may collect from the third party payer is the reasonable charge for the care provided less the appropriate deductible or copayment amount.

(c) *Claim from United States exclusive.* The only way for a third party payer to satisfy its obligation under 10 U.S.C. 1095 is to pay the facility of the uniformed service or other authorized representative of the United States. Payment by a third party payer to the beneficiary does not satisfy 10 U.S.C. 1095.

(d) *Assignment of benefits or other submission by beneficiary not necessary.* The obligation of the third party payer to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States. Nor is the obligation to pay dependent upon any other submission by the beneficiary to the third party payer, including any claim or appeal. In any case in which a facility of the Uniformed Services makes a claim, appeal, representation, or other filing under the authority of this part, any procedural requirement in any third party payer plan for the beneficiary of such plan to make the claim, appeal, representation, or other filing must be deemed to be satisfied. A copy of the completed and signed DoD insurance declaration form will be provided to payers upon request, in lieu of a claimant's statement or coordination of benefits form.

(e) *Preemption of conflicting State laws.* Any provision of a law or regulation of a State or political subdivision thereof that purports to establish any requirement on a third party payer that would have the effect of excluding from coverage or limiting payment, for any health care services for which payment by the third party payer under 10 U.S.C. 1095 or this part is required, is preempted by 10 U.S.C. 1095 and shall have no force or effect in connection with the third party payer's obligations under 10 U.S.C. 1095 or this part.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41101, Sept. 9, 1992; 65 FR 7727, Feb. 16, 2000; 67 FR 57740, Sept. 12, 2002]

### § 220.3 Exclusions impermissible.

(a) *Statutory requirement.* Under 10 U.S.C. 1095(b), no provision of any third party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided in a facility of the uniformed services shall operate to prevent collection by the United States.

(b) *General rules.* Based on the statutory requirement, the following are general rules for the administration of 10 U.S.C. 1095 and this part.

(1) Express exclusions or limitations in third party payer plans that are inconsistent with 10 U.S.C. 1095(b) are inoperative.

(2) No objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third party payers.

(3) Third party payers may not treat claims arising from services provided in facilities of the uniformed services less favorably than they treat claims arising from services provided in other hospitals.

(4) No objection, precondition or limitation may be asserted that is contrary to the basic nature of facilities of the uniformed services.

(c) *Specific examples of impermissible exclusion.* The following are several specific examples of impermissible exclusions, limitations or preconditions. These examples are not all inclusive.

(1) *Care provided by a government entity.* A provision in a third party payer's plan that purports to disallow or limit payment for services provided by a government entity or paid for by a government program (or similar exclusion) is not a permissible ground for refusing or reducing third party payment.

(2) *No obligation to pay.* A provision in a third party payer's plan that purports to disallow or limit payment for services for which the patient has no obligation to pay (or similar exclusion) is not a permissible ground for refusing or reducing third party payment.

(3) *Exclusion of military beneficiaries.* No provision of an employer sponsored program or plan that purports to make ineligible for coverage individuals who are uniformed services health care beneficiaries shall be permissible.

(4) *No participation agreement.* The lack of a participation agreement or

the absence of privity of contract between a third party payer and a facility of the uniformed services is not a permissible ground for refusing or reducing third party payment.

(5) *Medicare carve-out and Medicare secondary payer provisions.* A provision in a third party payer plan, other than a Medicare supplemental plan under § 220.10, that seeks to make Medicare the primary payer and the plan the secondary payer or that would operate to carve out of the plan's coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare is not a permissible ground for refusing or reducing payment as the primary payer to the facility of the Uniformed Services by the third party payer unless the provision:

(i) Expressly disallows payment as the primary payer to all providers to whom payment would not be made under Medicare (including payment under Part A, Part B, a Medicare HMO, or a Medicare+Choice plan); and

(ii) Is otherwise in accordance with applicable law.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41101, Sept. 9, 1992; 65 FR 7728, Feb. 16, 2000]

#### **§ 220.4 Reasonable terms and conditions of health plan permissible.**

(a) *Statutory requirement.* The statutory obligation of the third party to pay is not unqualified. Under 10 U.S.C. 1095(a)(1) (as noted in § 220.2 of this part), the obligation to pay is to the extent the third party payer would be obliged to pay if the beneficiary incurred the costs personally.

(b) *General rules.* (1) Based on the statutory requirement, after any impermissible exclusions have been made inoperative (see § 220.3 of this part), reasonable terms and conditions of the third party payer's plan that apply generally and uniformly to services provided in facilities other than facilities of the uniformed services may also be applied to services provided in facilities of the uniformed services.

(2) Except as provided by 10 U.S.C. 1095, this part, or other applicable law, third party payers are not required to

treat claims arising from services provided in or through facilities of the Uniformed Services more favorably than they treat claims arising from services provided in other facilities or by other health care providers.

(c) *Specific examples of permissible terms and conditions.* The following are several specific examples of permissible terms and conditions of third party payer plans. These examples are not all inclusive.

(1) *Generally applicable coverage provisions.* Generally applicable provisions regarding particular types of medical care or medical conditions covered by the third party payer's plan are permissible grounds to refuse or limit third party payment.

(2) *Generally applicable utilization review provisions.* (i) Reasonable and generally applicable provisions of a third party payer's plan requiring pre-admission screening, second surgical opinions, retrospective review or other similar utilization management activities may be permissible grounds to refuse or reduce third party payment if such refusal or reduction is required by the third party payer's plan.

(ii) Such provisions are not permissible if they are applied in a manner that would result in claims arising from services provided by or through facilities of the Uniformed Services being treated less favorably than claims arising from services provided by other hospitals or providers.

(iii) Such provisions are not permissible if they would not affect a third party payer's obligation under this part. For example, concurrent review of an inpatient hospitalization would generally not affect the third party payer's obligation because of the DRG-based, per-admission basis for calculating reasonable charges under § 220.8(a) (except in long stay outlier cases, noted in § 220.8(a)(4)).

(3) *Restrictions in HMO plans.* Generally applicable exclusions in Health Maintenance Organization (HMO) plans of non-emergency or non-urgent services provided outside the HMO (or similar exclusions) are permissible. However, HMOs may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-